LOUISVILLE FIRE PROTECTION DISTRICT
AMBULANCE MEMBERSHIP PROGRAM

2016 ANNUAL ENROLLMENT FORM

CARES: *Cost Avoidance & Reductions for Emergency Services*

Please Print

_____ _____ _____
Last Name First Name MI

_____
Address City Zip Code

_____
Phone

Please check the type of membership requested

☐ **$25 Individual** - covers only the individual signing this enrollment form.

☐ **$45 Couple** - covers the individual signing this enrollment form and spouse living at your residence.

☐ **$65 Family** - covers the individual signing this enrollment form and all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence.

☐ **$35 Senior Couple** - covers the individual signing this enrollment form, who must be age 55 or older, and spouse living at your residence.

☐ **$55 Senior Family** - covers the individual signing this enrollment form, who must be age 55 or older, and all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence.

Complete, sign and return your Enrollment Form with payment to:
Louisville Fire Protection District, 895 W. Via Appia, Louisville, CO 80027
Please call our office if you have any questions. Phone: 303-666-6595

Please list all family members, including unmarried children under age 25 and other dependents listed on your tax return and regularly living at your residence.

Last Name	First Name	MI	Relationship	Date of Birth	Social Security #

INSURANCE INFORMATION

Circle all appropriate: Medical Insurance Auto Insurance Medicare

Primary Medical Ins Co:_____

Policy or ID #_____ Group: _____

Address:_____

Phone:

Secondary Medical Ins Co:_____

Policy or ID #_____ Group: _____

Address:_____

Phone:

Auto Ins Co:_____

Policy or ID #_____ Group: _____

Address:_____

Phone:

AGREEMENT

I represent that the foregoing information is true and accurate. I have read and agree with the terms of the Ambulance Membership Program Agreement. I further understand that my insurance provider(s) will be billed for payment, and that any co-payment required under my insurance policy(ies) not paid by my insurance provider(s) will be paid by the Louisville Fire Protection District Ambulance Membership Program in accordance with the terms of the Program in full satisfaction of Louisville Fire Protection District's emergency medical/ambulance transport charges.

To my insurance carrier(s) or other provider of medical benefits:

- I authorize a copy of this Enrollment Form and Agreement to be used in lieu of the original on file at the Louisville Fire Protection District's office.
- I authorize payment of benefits be made directly to the Louisville Fire Protection District for emergency medical/ambulance transport services for eligible family members or myself.
- I authorize and direct reimbursement for emergency medical/ambulance services pursuant to my policy(ies) to be sent directly to the Louisville Fire Protection District.

_____
Signature

_____
Date

(Please keep copy for your records.)

I heard about this program from:

☐ Friend/Family
☐ Louisville Fire Protection District Website
☐ Other_____